STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY PETE WILSON, *Governor*

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
(916) 322-1478

January 25, 1993
CMSP Letter # 93-2

TO: All CMSP County Welfare Directors

SUBJECT: VERIFICATION OF FISCAL YEAR 1991-92 CMSP ELIGIBILITY EXPENDITURES

Enclosed is a worksheet listing County Medical Services Program (CMSP) eligibility expenditures for fiscal year 1991-92.

Since this data will be used to determine necessary recoupments and reallocations of these funds, it is necessary that you review the accuracy of this data for your County. If your County has submitted Supplemental (adjusted) Administrative Cost Claims which impact CMSP, it is likely that they are not reflected in this data. Such claims will be considered if you complete and return the enclosed "CMSP Amended Eligibility Expenditure Report" by February 15, 1993. Please note that supplemental claims filed after December 31, 1992 can not be considered since that date is the cut off for the 1991-92 fiscal year. This form must also be used to provide "corrected" information from the original Administrative Cost Claims submitted for each quarter. Completed reports should be mailed to :

Office of County Health Services
Attention: Mr. Albert Cooper
Department of Health Services
State of California
714 P Street
P. O. Box 942732
Sacramento, CA 94234-7320

If you have any questions regarding the report or this letter, please contact Mr. Albert Cooper, at (916) 322-1615.

Sincerely,

Jim Martinez, Chief
County Medical Services Program

Enclosures

CMSP ELIGIBILITY EXPENDITURES /21/93
STATE FISCAL YEAR 1991-92

COUNTY	FIRST QUARTER	SECOND QUARTER	THIRD QUARTER	FOURTH QUARTER	TOTAL
ALPINE	$612	$303	$898	$1,853	$3,666
AMADOR	$13,377	$9,574	$10,899	$9,812	$43,662
BUTTE	$96,492	$189,358	$159,340	$168,990	$614,180
CALAVERAS	$22,441	$21,935	$18,350	$17,732	$80,458
COLUSA	$18,914	$11,436	$13,648	$20,633	$64,631
DEL NORTE	$24,593	$31,685	$25,657	$29,091	$111,026
EL DORADO	$88,690	$79,548	$90,238	$83,988	$342,464
GLENN	$21,998	$10,530	$16,410	$14,991	$63,929
HUMBOLDT	$89,267	$147,395	$185,959	$90,676	$513,297
IMPERIAL	$158,312	$155,152	$158,694	$137,148	$609,306
INYO	$16,460	$16,795	$17,433	$49,719	$100,407
KINGS	$100,728	$82,674	$82,621	$97,790	$363,813
LAKE		$49,672	$35,414	$42,054	$127,140
LASSEN	$7,790	$20,715	$21,130	$20,315	$69,950
MADERA	$84,178	$108,898	$98,418	$147,280	$438,774
MARIN	$179,671	$206,348	$171,704	$208,936	$766,659
MARIPOSA	$8,615	$10,595	$8,865	$12,971	$41,046
MENDOCINO		$78,400	$63,867	$94,029	$236,296
MODOC	$4,133	$4,489	$5,983	$5,737	$20,342
MONO	$11,094	$10,046	$11,772	$13,384	$46,296
NAPA	$61,140	$55,906	$41,213	$27,523	$185,782
NEVADA	$48,519	$46,967	$33,273	$41,315	$170,074
PLUMAS	$12,567	$14,369	$16,003	$1,466	$44,405
SAN BENITO	$10,919	$16,942	$31,692	$33,185	$92,738
SHASTA	$92,260	$120,287	$159,766	$132,319	$504,632
SIERRA	$2,241	$2,335	$2,653	$1,762	$8,991
SISKIYOU	$23,119	$48,571	$38,641	$49,996	$160,327
SOLANO	$138,736	$158,348	$174,621	$188,948	$660,653
SONOMA	$191,087	$200,545	$169,945	$181,347	$742,924
SUTTER	$32,872	$30,543	$37,951	$37,092	$138,458
TEHAMA	$36,057	$50,600	$63,507	$89,432	$239,596
TRINITY	$11,217	$10,264	$13,556	$17,004	$52,041
TUOLUMNE	$37,614	$33,470	$38,636	$29,787	$139,507
YUBA	$68,089	$68,183	$74,420	$93,823	$304,515
TOTAL	$1,713,802	$2,102,878	$2,093,177	$2,192,128	$8,101,985

COUNTY MEDICAL SERVICES PROGRAM
AMENDED ELIGIBILITY EXPENDITURE REPORT
FOR THE STATE FISCAL YEAR 1991-92

Quarter: _____

Amount from DHS Worksheet	$_____
Correct Amount from Regular Cost Claim	$_____
Supplemental Claim Date: _____	
Supplemental Claim Amount	$_____
Supplemental Claim Date: _____	
Supplemental Claim Amount	$_____
Amended Net Total for Quarter	$_____

Quarter:

Amount from DHS Worksheet	$_____
Correct Amount from Regular Cost Claim	$_____
Supplemental Claim Date: _____	
Supplemental Claim Amount	$_____
Supplemental Claim Date: _____	
Supplemental Claim Amount	$_____
Amended Net Total for Quarter	$_____

I certify under penalty of perjury that the amounts shown above are correct and accurately reflect the information which has been submitted to the State Department of Social Services on regular and supplemental adjusted Administrative Cost Claims.

Printed Name/Title	Signature	Date
_____	_____	_____